DENTURIST SERVICES

July 2000

Department of Public Health & Human Services
Medicaid Services Bureau
PO Box 202951
Helena MT 59620-2951

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DENTURIST SERVICES

A. DEFINITIONS

1. **DENTURIST SERVICES** --are those full or partial denture services which are provided by a licensed denturist. Services provided must be within the scope of their profession as defined by law.

2. **MEDICALLY NECESSARY**--A service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in a patient which:

a. endanger life;
b. cause suffering or pain;
c. result in illness or infirmity;
d. threaten to cause or aggravate a handicap; or
e. cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment more suitable for the recipient requesting the service or, when appropriate, no treatment at all.

For more information, call the Surveillance & Utilization Review Section of the Department's Quality Assurance Division at (406) 444-2037.

3. **THIRD PARTY (TPL)**--An individual, institution, corporation or a public or private agency which may be or is liable to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of services provided by the Montana Medicaid Program (other insurance).

4. **DPHHS, STATE AGENCY**--The Montana Department of Public Health and Human Services (Department) is the designated State Agency that administers the Medicaid or Title XIX Program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 46, Chapter 12. These rules are developed within the authority granted under the state and federal statutes and federal regulations cited above.

5. **CONSULTEC, FISCAL AGENT**--Consultec is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 46.12 et seq.

6. **PRESUMPTIVE ELIGIBILITY** -- Under the Omnibus Budget Reconciliation Act of 1986, Medicaid payments are available for ambulatory prenatal care for pregnant women during a presumptive eligibility period before she has formally applied for Medicaid. The Department began offering this program in January 1991 to improve services to low income pregnant women.

Women who qualify for presumptive eligibility receive a Form DPHHS FA-428, Presumptive Eligibility Notice of Decision, which indicates the approval date of coverage. **Medical providers must call 1-800-932-4453 to confirm presumptive eligibility before providing a service.** Submit claims for services provided to presumptive eligibility recipients to Consultec at P.O. Box 8000, Helena, MT 59604.

7. **BASIC MEDICAID**--Able-bodied Medicaid adult recipients (21 years or older) are required to participate in Families Achieving Independence in Montana (FAIM). As a participant in FAIM, adults will only be eligible for BASIC Medicaid. BASIC Medicaid ***excludes*** coverage for dental services, durable medical equipment and supplies, eye examination, eyeglasses, hearing aids, audiology services, and personal care services.

8. **FULL MEDICAID**--FULL Medicaid indicates a recipient will receive the full scope of Medicaid benefits. The following group of people would receive FULL benefits: pregnant women participating in FAIM, children under age 21 participating in FAIM, SSI Recipients (aged, blind, and disabled) and elderly or disabled recipients.

9. **ESSENTIAL FOR EMPLOYMENT SERVICES FOR BASIC MEDICAID RECIPIENTS --** Medicaid may reimburse for denturist services for recipients who are employed or have been offered employment.

B. PHONE NUMBERS AND ADDRESSES

1. CONSULTEC

For claims processing information call or write:

Provider Relations Department
Consultec
P.O. Box 4936
Helena, MT 59604
Helena & Out of State: (406) 442-1837
In State Toll Free: (800) 624-3958

For help with claims that have third party liability (other insurance) involved, call or write:

Third Party Liability Unit
Consultec
P.O. Box 5838
Helena, MT 59604
Helena & Out of State: (406) 442-1837
In State Toll Free: (800) 624-3958

2. DPHHS

For policy questions and problems related to Medicaid, call or write:

Department of Public Health and Human Services
Health Policy and Services Division
1400 Broadway
PO Box 202951
Helena, MT 59620-2951
Telephone Number: (406) 444-3182

Some specific services will be handled by other Divisions within the Department.

3. MEDICAID ELIGIBILITY INFORMATION

When possible, providers should view the patient's ID card for eligibility information. There are a number of other resources available to providers for the verification of Medicaid eligibility. These include Automated Voice Response, FAXBACK, the Medicaid Eligibility and Payment System (MEPS), and the Public Access System.

Two options are to call Consultec's **Automated Voice Response** at (800) 714-0060 or **FAXBACK** at (800) 714-0075. Automated Voice Response will let you know if a Medicaid recipient has eligibility for a particular date of service. Just call the 800 number from your touch-tone phone. FAXBACK will fax you a report of the recipient's eligibility including managed care details, insurance coverage, Medicare coverage, etc. To sign up for FAXBACK, call Consultec at (800) 624-3958 in state and (406) 442-1837 in Helena and out-of-state. Have your Medicaid provider number and FAX number ready when you call.

The **MEPS (Medicaid Eligibility and Payment System) system** is available via the Medicaid kiosk in the DPHHS room of the Montana Virtual Human Services Pavillion @ http://vhsp.dphhs.state.mt.us. There is no charge for MEPS, but you must complete an access request form prior to using the system. The form can be downloaded from the site. Once you have submitted your access request form, the MEPS security officer will contact you, verify information you have provided and give you a MEPS password. The MEPS system offers recipient eligibility and claims status history.

The **Public Access System** is accessed using a PC and modem. Medicaid providers may subscribe to the Public Access System by contacting:

Operations and Technology Division
Department Of Public Health and Human Services
P.O. Box 4210
Helena, MT 59604
Telephone Number: (406) 444-1752

The cost of subscribing to the Public Access System is $100 every six months. Once connected, providers can dial in 24 hours a day, 7 days a week to verify Medicaid eligibility information for recipients.

THE ABOVE-MENTIONED ELIGIBILITY VERIFICATION SYSTEMS **DO NOT** CHECK PROGRAM BENEFIT LIMITS.

C. DENTURIST PROVIDER REQUIREMENTS

1. TIMELY FILING LIMIT

Providers shall submit a "CLEAN" claim:

a. within 365 days of
   - the date of service,
   - the date retroactive eligibility is determined,
   - the date disability is determined;

OR

b. within 6 months of
   - the date Medicare **paid**;

whichever is **LATER.**

A **"clean claim"** is one that can be processed for payment without correction, additional information, or documentation from the provider.

Date of submission is the date a claim is stamped received by Consultec or the Department**. A CLAIM LOST IN THE MAIL IS NOT CONSIDERED RECEIVED.**

A common reason for exceeding the timely filing limit is waiting for another insurance to pay. To avoid this problem, the provider may bill Medicaid without an answer from the insurer if it has been 90 days since they billed the insurance. See Section VII, Part F (2) (b) of the General Medicaid Provider Handbook (yellow in color). If a provider subsequently receives reimbursement from another insurance company, the provider will need to adjust the Medicaid claim to show receipt of payment. Instructions for adjustments can be found in Section VIII-5, Part F of the General Medicaid Provider Handbook (yellow manual).

2. "NO SHOW" APPOINTMENTS

A "No Show" appointment occurs when a recipient fails to arrive at a provider's office for a scheduled visit and did not cancel or reschedule the appointment in advance. "No Show" appointments are not a covered service and cannot be billed to Medicaid.

The provider cannot bill the Medicaid recipient for a "No Show." If a provider bills Medicaid for such an occurrence, it will be construed as a "false claim". The provider will be subject to state and federal penalties.

3. RECIPIENT COPAYMENT

Providers may choose to collect recipient copayment at the time of service or bill the recipient later. According to federal regulation, a provider cannot deny services to a Medicaid recipient due to the recipient's inability to pay the co-payment at the time services are rendered. However, the recipient's inability to pay the co-payment at the time services are rendered does not lessen the recipient's obligation to pay the co-payment.

As providers, you must treat Medicaid patients and private pay patients equally. If you refer the private pay patient to a collection agency for failure to pay for services rendered, you may also refer the Medicaid patient to a collection agency for failure to pay co-payment charges. If it is your office policy to request the private pay patient to seek another health care provider at the time you refer to a collection agency, then you may also request the Medicaid patient to seek another health care provider at the time you refer to a collection agency.

It is suggested a notice be posted in the waiting room explaining to all patients the office's policy regarding the patient's responsibility for payment, including the cost-sharing obligation (co-payment).

Section V of the yellow General Medicaid Provider Handbook details recipient responsibility for the copayment and the amount per service. The maximum co-payment per state fiscal year (July through June) for a Medicaid recipient is $200. The claims processing system tracks all co-payments applied to the claims paid for each Medicaid recipient. At the time the maximum cap of $200 is reached, no further co-payment is applied to the claims paid. Thereafter, the recipient's co-payment cap information will appear on the Medicaid card.

4. USUAL AND CUSTOMARY CHARGES

All charges for services submitted to Medicaid must be made in accordance with an individual provider's USUAL AND CUSTOMARY charges to the general public unless:

1. A provider has entered into an agreement with the Department to provide services at a negotiated rate, or

2. A provider has been directed by the Department to submit charges at a Department specified rate.

3. When submitting a claim to Medicaid, please bill using your Usual and Customary charge, not the Medicaid reimbursement fee.

5. MEDICAID PAYMENT IS PAYMENT IN FULL

As a condition of participation, providers must accept as payment in full the amount paid by Medicaid for any covered service provided to an eligible recipient. Providers may not seek any payment in addition to or in lieu of the amount paid by Medicaid, except Medicaid copayment specified in the yellow General Medicaid Provider Handbook, from a recipient or his/her representative.

There are instances where recipients have other insurance, which pay for denturist services at a higher rate than allowed by Medicaid. In these instances, a provider may bill Medicaid and receive a payment from Medicaid equaling to $0.00. This is because the amount paid by the insurance company is more than what Medicaid would have allowed for the same procedure. Medicaid payment for dental services is based on a fee schedule for each procedure code as listed in this manual and does not make up the difference between what an insurance company paid and the billed amount by the dental provider.

Example 1 C Service Covered by TPL & Medicaid C TPL Greater than Medicaid on all Services

In this instance, the recipient has both Blue Cross/Blue Shield and Medicaid. The denturist accepted both insurances. The denturist received payment from Blue Cross/Blue Shield totaling $518.00. The Explanation of Benefits from both Blue Cross/Blue Shield and Medicaid show the following:

Allowed Procedures	Description	Medicaid Allowed Amount	Insurance Allowed Amount	Provider Charged Amount
0140	Oral Examination	$ 17.00	$ 18.00	$ 25.00
5110	Complete Upper denture	$390.00	$500.00	$600.00
Total for visit		$407.00	$518.00	$625.00

The denturist would receive a payment of $0.00 from Medicaid because the insurance company allowed more for services provided than Medicaid allowed for each service. Because the denturist accepted this recipient as a Medicaid recipient, the difference between the amount allowed by the insurance company and the total amount for services provided cannot be billed to the recipient, even though Medicaid paid $0.00--this is considered payment in full.

Example 2 C Service Covered by TPL & Medicaid C Medicaid Greater than TPL on all Services

In this instance, the recipient has both Blue Cross/Blue Shield and Medicaid. The denturist accepted both insurances. The denturist received a payment from Blue Cross/Blue Shield totaling

$310.00. The Explanation of Benefits from Blue Cross/Blue Shield and Medicaid shows the following:

Allowed Procedures	Description	Medicaid Allowed Amount	Insurance Allowed Amount	Provider Charged Amount
0140	Oral Examination	$ 17.00	$ 10.00	$ 25.00
5110	Complete Upper Denture	$390.00	$300.00	$600.00
Total allowed for visit		$407.00	$310.00	$625.00

The denturist would receive a payment of $97.00 from Medicaid because Medicaid allowed more for services provided than the insurance allowed for each service. Because the denturist accepted this recipient as a Medicaid Recipient, the difference between the amount allowed by the insurance company, the amount allowed by Medicaid and the total amount for services provided cannot be billed to the recipient, even though Medicaid paid $97.00, this is considered payment in full.

Example 3 C Services Covered by TPL & Medicaid C TPL Greater than Medicaid on SOME Services

In this instance, the recipient has both Blue Cross/Blue Shield and Medicaid. The denturist accepted both insurances. The denturist received a payment from Blue Cross/Blue Shield totaling $500.00. The Explanation of Benefits from Blue Cross/ Blue Shield and Medicaid shows the following:

Allowed Procedures	Description	Medicaid Allowed Amount	Insurance Allowed Amount	Provider Charged Amount
0140	Oral Examination	$ 17.00	$ 0.00	$ 25.00
5110	Complete Upper Denture	$390.00	$500.00	$600.00
Total allowed for visit		$407.00	$500.00	$625.00

This example is somewhat more complicated. The insurance company paid $500.00 for the upper denture but did not allow payment for the oral examination. In this instance, the denturist should bill only procedure code 0140 to Medicaid to receive a payment for $17.00. This example is different from Example 1 because the insurance paid more on both procedures. Even though the total reimbursement amount on one procedure code is greater than allowed by Medicaid for both procedures, the provider did not receive any payment from the insurance company for the exam. Therefore, the denturist can bill Medicaid for the oral examination and show a $0.00 payment from the insurance. Again, once the provider receives payment from Medicaid, this is considered payment in full for services provided. The difference between the amount reimbursed by the insurance company and Medicaid cannot be billed to the recipient.

6. ACCEPTING RETROACTIVE MEDICAID ELIGIBILITY

When a private-pay patient becomes retroactively eligible for Medicaid and is being treated by a medical provider who accepts Medicaid patients, the patient may request prior services be billed to Medicaid by that provider. At the discretion of the provider, the patient may be accepted as a Medicaid patient or be required to continue as a non-Medicaid patient if the patient wishes to be treated by that provider.

The provider may accept the patient as a Medicaid patient from the date of the request forward, or go back to the patient's retroactive eligibility date. If the provider accepts the retroactive date and the patient has been billed for services and made full payment, the provider must refund the payment before billing Medicaid for those services. If the recipient has made partial payment, but not payment in full, the provider may either refund the payments to the recipient or show them as a credit on claims submitted to Medicaid. Payments made by the patient's third party payer must be credited as third party payments when billing Medicaid.

If a recipient becomes retroactively eligible for Medicaid and has made no payment for the services, the provider may:

1. accept the Medicaid ID card and bill the services to Medicaid in full; or

2. may inform the patient that Medicaid is not acceptable and continue to pursue payment from the client as a private pay patient.

If the provider does not accept Medicaid, the patient may sever the relationship and the provider may bill the patient only for those services actually provided.

7. RECORD KEEPING, RETENTION, AND ACCESS

All medical and financial records that accurately and completely reflect drugs, prescriptions, equipment and services provided under the Medicaid Program must be maintained by a provider, and furnished on request to the Department or its authorized representative for a period of ***six years and three months from the date the service was rendered***. The Department shall have access to all records so maintained and retained regardless of a provider's continued participation in the program.

The Department and its designees shall have the right to inspect or evaluate the quality, appropriateness and timeliness of services performed by providers, and to inspect and audit all records required by the Department. All information regarding a recipient or applicant, in addition to medical records, is confidential and shall be used solely for purposes related to the administration of the Montana Medicaid Program. This information shall not be divulged by the provider to any person other than the State of Montana, the Department, or its designees, without the written consent of the recipient or applicant, or their court appointed guardian.

D. BENEFITS AND LIMITATIONS

1. CALCULATING SERVICE LIMITS

Any service which is covered only at specified intervals for adults will have a notation next to the procedure code informing you of the limit, refer to Section H, Covered Denture Services and Procedure Codes. **(Service limits do not apply to individuals up to and including age 20).** When scheduling appointments, please be aware limits are controlled by our computerized claims payment system in this manner.

Limits on these services are controlled by matching the date on the last service against the current service date to assure the appropriate amount of time (six months, 1 year, or 3 years) has elapsed.

For Example: If an adult received a denture on February 26 and the same service was provided again on February 26, 10 years later, the claim would be denied as 10 years would not have passed between services. If the service were provided on February 27, 10 years later, it would be paid.

Denturist providers may call Consultec to inquire on the last date of service for those procedure codes that have time limits or other limitations of dental services. **By calling Consultec, the denturist provider can calculate service limitations but does not guarantee payment of service for service limited procedures because recipients have to be eligible for Medicaid when services are provided.**

2. QMB ONLY (Qualified Medicare Beneficiary)

The QMB program allows Medicaid to pay the Medicare premium, coinsurance and deductibles for certain recipients. Some recipients may qualify for the QMB Program only or both QMB and Medicaid Programs. The QMB only recipients are issued a green card with QMB ONLY overprinted on the center of the card. **This different card is to alert you that the recipient does not have Medicaid benefits.** Recipients designated QMB ONLY are entitled to Medicare benefits, not Medicaid. This is of particular concern to dentists and denturists because Medicare does not cover dentures or most other dental work. If needed, there is further information about the QMB program in the yellow Provider Handbook.

E. FAIM - FAMILIES ACHIEVING INDEPENDENCE IN MONTANA

1. OVERVIEW

In February 1996, Montana implemented a comprehensive welfare reform package called Families Achieving Independence in Montana (FAIM). FAIM is a welfare reform project incorporating Food Stamps, TANF - Temporary Assistance to Needy Families (formerly AFDC), and Medicaid. The goals of FAIM include strengthening the values of family, work, and responsibility while increasing recipients' personal dignity on their way to achieving self-sufficiency. Since participation in FAIM affects Medicaid coverage for able-bodied adults 21 years of age and older, it is especially important to check a recipient's Medicaid card closely. For details on what to look for on the Medicaid card, refer to Item 5; for a sample Medicaid card, please refer to Item 6.

2. HOW FAIM PARTICIPATION AFFECTS A RECIPIENT'S MEDICAID BENEFITS

For FAIM participants who are 21 years and older and **NOT** pregnant, there are two changes to their Medicaid coverage:

- **They are only eligible for BASIC Medicaid**. **BASIC** Medicaid *excludes* coverage for dental services, denturist services, durable medical equipment and supplies, eye examinations, eyeglasses, hearing aids, audiology services, and personal care services.

There is no change to Medicaid benefits received by the following groups:

Pregnant women participating in FAIM
Children under age 21 participating in FAIM
SSI recipients (aged, blind, and disabled)
Elderly or disabled recipients

These recipients are eligible for **FULL** Medicaid (i.e. the full scope of Medicaid benefits).

3. DENTAL COVERAGE UNDER FAIM/BASIC MEDICAID

If the word "BASIC" appears under the adult recipient's name on his or her Medicaid card, **dental services are not covered under Medicaid unless it is an emergency. All denturist services for CHILDREN (up to the age of 21) and pregnant adults on FAIM are still available.**

4. SERVICES EXCLUDED UNDER BASIC MEDICAID COVERED AS ESSENTIAL FOR EMPLOYMENT

In very limited circumstances, Medicaid will cover a service normally excluded under "BASIC" Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the recipient on "BASIC" Medicaid will have a signed form (FA-782) which the service provider must submit with the claim. To receive denturist services as an Essential to Employment benefit, the recipient must contact their FAIM Coordinator to obtain the form (FA-782) necessary to apply for this benefit. Please refer the recipients to their FAIM Coordinator prior to providing any denturist services that may qualify for this program.

Reimbursement is the same for approved services as they would be for a FULL Medicaid recipient.

5. HOW TO TELL IF A RECIPIENT IS ON BASIC MEDICAID OR FULL MEDICAID

There are three ways to determine whether a Medicaid recipient has **BASIC** or **FULL** Medicaid:

A. Check their Medicaid card. If a recipient has:

BASIC Medicaid - the word "BASIC" will appear under the recipient's last name. A Medicaid card may have a mix of recipients with **BASIC** and **FULL** Medicaid, so check the space below the specific recipient's name.

FULL Medicaid - the word "FULL" will appear under the recipient's last name, *or* it will be blank.

B. Check the TEAMS Public Access Screen. If the recipient has:

BASIC Medicaid - The letters "BM" (**BASIC** Medicaid) will appear in the "Medicaid Coverage" column. Please keep in mind the coverage is that in effect for the date entered into the "LAST DOS" field.

FULL Medicaid - The letters "FC" will appear in the "Medicaid Coverage" column *or* it will be blank in that column. Please keep in mind the coverage is that in effect for the date entered into the "LAST DOS" field.

C. Call Medicaid **Voice Response System** at 1-800-714-0060 or **Faxback System** at

1-800-714-0075. If a recipient has:

BASIC Medicaid - Voice response will say "Recipient [ID number] is only eligible for **BASIC** services on [date]"

Faxback will have "Medicaid - eligible - Basic"

FULL Medicaid - Voice response will confirm Medicaid eligibility; it will NOT say the word "Full"

Faxback will have "Medicaid - eligible - yes"; it will NOT print the word "Full"

To use the Voice Response System, call the toll-free 800 number from your touch tone phone. You do not need to sign up ahead of time for Voice Response; all you need is a touch-tone phone, your active Montana Medicaid provider number and the Medicaid recipient's SSN or TEAMS identification number. It is available 24 hours a day, 7 days a week.

You must sign up ahead of time for the Faxback System. To sign up for Faxback, call Consultec (with your fax number and provider number) at 1-800-624-3958 in state or 406-442-1837 in Helena and out-of-state. Once you have signed up, Faxback is available 24 hours a day, 7 days a week.

6. MEDICAID CARD

G. LIMITS

Submitting a prior authorization is necessary only if the requests fall outside the parameters of the limitations placed on the procedure. Approval of PA's will depend upon the medical necessity of services being submitted. The Department or its designee will determine if the procedure will be authorized. Please send all prior authorization requests to the address below.

Consultec
P.O. Box 8000
Helena, MT 59604

ALL PRIOR AUTHORIZATION REQUESTS MUST BE SENT THROUGH CONSULTEC

2. REIMBURSEMENT

Payment for denturist services shall be limited to the lowest of the provider's usual and customary charge for the service or the Medicaid fee schedule.

Under the Administrative Rules of Montana (ARM 46.12.605), reimbursement is based on the following:

1. Reimbursement for services delivered to adults is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 65.2% of the provider's usual and customary charge for the service. Services delivered to adults are services provided while the recipient is age 21 and over.

2. Reimbursement for services delivered to a child is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 80% of the provider's usual and customary charge for the service. Services delivered to children are services provided while the recipient is up to and including age 17.

3. Reimbursement for services delivered to individuals age 18 through 20 is the fee specified in the fee schedule for adults, or if reimbursement is based on the "by report" method 80% of the provider's usual and customary charge for the service.

G. BILLING PROCEDURES

All claims must be submitted on the 1990 or 1994 version of the American Dental Association (ADA) claim form using ADA procedure codes. These claim forms may be obtained from most office supply stores or print shops that carry other office forms.

Completed PA request forms and completed claim forms are submitted to Consultec at the

following address:

Consultec
P.O. Box 8000
Helena, MT 59604

Questions about claims processing issues, reimbursement rates, and completing forms should be addressed to Consultec at **1-800-624-3958** or **(406) 442-1837**.

Questions about Medicaid policy should be addressed to the Dental Program Officer at the Medicaid Services Bureau. Telephone number is **(406) 444-3182.**

Medicaid does not supply the ADA procedure code book "CDT-3 Current Dental Terminology." The CDT-3 book can be ordered from the ADA at the following address:

American Dental Association
Council on Dental Care Programs
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(800) 947-4746

REMEMBER:

- **ADA procedure codes must be used. The complete code descriptions, and definitions of appropriate circumstances for billing each code are published in the ADA CDT-3 book. Additional limitations and requirements specific to Montana Medicaid are published separately below in section J of this manual.**

H. EPSDT SERVICES, FOR INDIVIDUALS AGE 20 AND UNDER

Limits on **medically necessary services** (e.g., exams, prophy's, x-rays, etc.) do not apply to recipients age 20 and younger as part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

Medicaid now has a systematic way of exempting children from the service limits. Therefore, **providers no longer need to indicate "EPSDT" on the claim form** for the limits to be overridden.

If you are providing a procedure not included in this manual to a child and it is Medically Necessary, please contact the Dental Program Officer for claims processing instructions.

I. COVERED DENTURE SERVICES AND PROCEDURE CODES

Limitations or requirements for the dental codes are listed on the tables below.

1. PRESCRIPTION REQUIREMENTS:

A dentist's prescription is required in the following circumstances:

- All partial denture work; and
- All immediate denture work.

Denturists are responsible for ensuring the dentist's prescription is kept in the recipient file. Medicaid will not longer require proof of prescription be submitted to obtain prior authorization.

A dentist's prescription is no longer required for any denture work other than what is indicated above.

2. DIAGNOSTIC

The collection and recording of some data and components of the dental/denture examination may be delegated: however, the evaluation, diagnosis, and treatment planning is the responsibility of the dentist/denturist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialist.

3. PROSTHODONTICS

A partial denture five years or older may be replaced by full and/or partial dentures. Full dentures ten years old or older may be replaced when the treating dentist documents the need for replacement. Payment for the denture includes payment for any tissue conditioners provided. Complete and partial dentures include routine post delivery care.

Medicaid will replace lost dentures with a lifetime limit of **ONE** set. The claim form must include the age of the lost dentures and the term "Lost Dentures" written in the remarks section of the claim.

The above limits may be exceeded when the dentist and the Department consultant agree the current dentures are causing the patient serious physical health problems. In these situations, the provider should submit a PA request to Consultec.

4. BENEFITS/LIMITATIONS

The codes listed below only include procedures that have a descriptive limitation/requirement. For more information related to prior authorization, please refer to the dental fee schedule.

CODE	PROCEDURE DESCRIPTION	LIMITATION OR REQUIREMENT
D0140	Limited oral exam - problem focused	Referral for a specific problem, emergencies, trauma or acute infections
D0470	Diagnostic Models Also known as diagnostic casts or study models	**Limited to individuals age 20 and under**
D0471	Diagnostic Photographs Includes both traditional photograph and images obtained by intraoral cameras	**Limited to individuals 20 and under**
D5110	Complete upper	Call Consultec to verify if dentures have been paid within the past 10 years.
D5120	Complete lower	Call Consultec to verify if dentures have been paid within the past 10 years.
D5130	Immediate upper	Includes follow-up care only. Does not include required rebasing/relining procedures.
D5140	Immediate lower	Includes follow-up care only. Does not include required rebasing/relining procedures.
D5211	Upper partial-resin base (including any conventional clasps, rests and teeth)	Replacing at least 1 anterior tooth and/or any number of posterior teeth may be replaced.
D5212	Lower partial-resin base (including any conventional clasps, rests and teeth)	Replacing at least 1 anterior tooth and/or any number of posterior teeth may be replaced.
D5213	Upper partial-cast metal base with resin saddles (including any conventional clasps, rests and teeth)	Replacing at least 1 anterior tooth and/or any number of posterior teeth may be replaced.
D5214	Lower partial-cast metal base with resin saddles (including any conventional clasps, rests and teeth)	Replacing at least 1 anterior tooth and/or any number of posterior teeth may be replaced.

D5410	Adjust complete denture-upper	The first 3 adjustments after dentures are placed are included in the denture price. Any additional or yearly adjustments can be billed using this code
D5411	Adjust complete denture-lower	See limitations under procedure code D5410
D5421	Adjust partial denture-upper	See limitations under procedure code D5410
D5422	Adjust partial denture-lower	See limitations under procedure code D5410
D5520	Replace missing or broken teeth-complete denture (each tooth)	Each additional tooth needs to be billed on separate lines with the tooth number indicated in the tooth number column.
D5610	Repair resin saddle or base	No teeth or metal involved
D5710	Rebase complete upper denture (jump or duplicate)	Dentures must be 5 years or older.
D5711	Rebase complete lower denture (jump or duplicate)	Dentures must be 5 years or older.
D5720	Rebase upper partial denture (jump or duplicate)	Dentures must be 5 years or older.
D5721	Rebase lower partial denture (jump or duplicate)	Dentures must be 5 years or older.
D5820	Interim partial denture (upper) Bonded or Removable Price includes up to 4 teeth. No payment beyond 4 teeth.	**Must supply 1 to 4 anterior teeth.** Use of a flipper is considered a partial denture and the partial denture limits apply. Includes use of FiberCore.
D5821	Interim partial denture (lower) Bonded or Removable	Same limitations as in D5820 above.
D9410	House call (also used for nursing home visits)	One nursing home call per day even when multiple patients are seen.

5. FEE SCHEDULE

All listed procedures are covered by the Medicaid program and must be used in conjunction with the limits listed in Item 17. If CDT-3 codes exist and are not listed in the Department Fee schedule, the items are not a covered service of the Medicaid program. Services that are not covered or exceed the specified limits can be billed to the individual.

Fee schedules may be obtained from Consultec, P. O. Box 8000, Helena, MT 59601 or the Internet at **www.dphhs.state.mt.us/hpsd/**.

Codes D0340, D0460, D0470, D0471, D1351, D3230 and D3240 without the EP modifier are allowed only for recipients ages 18 through 20. These codes are not covered for recipients ages 21 and older.